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Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

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NVS2811HIC

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STREET ADDRESS, CITY, STATE, ZIP CODE

1664 DEEP SPRING AVE
LAS VEGAS, NV 89123

(X2) MULTIPLE CONSTRUCTION
A. BUILDING
B. WING

O5/29/2009

STREET ADDRESS, CITY, STATE, ZIP CODE

1664 DEEP SPRING AVE
LAS VEGAS, NV 89123

(X4) ID
PREFIX

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PREFIX

(EACH CORRECTIVE ACTION SHOULD BE

COMPLETED

(X3) DATE SURVEY
COMPLETED

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C W HOME CARE		1664 DEEP SPRING AVE LAS VEGAS, NV 89123					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FI REGULATORY OR LSC IDENTIFYING INFORMAT		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE		
H 000	Initial Comments		H 000				
	This Statement of Deficiencies was generated as a result of a State Licensure survey conducted in your facility on 05/29/09.						
	This State Licensure survey was conducted authority of NAC 449, Homes for Individual Residential Care, adopted by the State Boar Health on November 29, 1999.						
	The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state or local laws.						
	The census at the time of the survey was tw	<i>1</i> 0.					
	Two (2) resident file and zero (0) employee were reviewed.	files					
	The following deficiencies were identified:						
H 019	Director Duties-No FA/CPR		H 019				
	NAC 449.15523 Director: Duties. (NRS 449.249) The director of a home shall: 4. Ensure that a caregiver, who is capable of meeting the needs of the residents and has been trained in first aid, and cardiopulmonary resuscitation, is on the premises of the home at all times when a resident is present.						
	This Regulation is not met as evidenced by Based on record review and staff interview of 05/29/09 the facility failed to ensure that 1 of 100 cm.	on					

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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NVS2811HIC		NVS2811HIC		B. WING		05/29/2009				
NAME OF PROVIDER OR SUPPLIER			STREET ADD	RESS, CITY, STA	ATE, ZIP CODE	•				
C W HOME CARE				1664 DEEP SPRING AVE LAS VEGAS, NV 89123						
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHO (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE			
H 019	Continued From page 1			H 019						
	1caregiver had received training in cardiopulmonary resuscitation (CPR) and first aid. Findings include:									
		able files to review for e Administrator of the facility,								
H 033	Safety&Sanitation-Fire	st Aid Kit		H 033						
	NAC 449.15525 Req sanitation of facility. (2. A home must conta (c) A first-aid kit;	•	d							
	Based on observation	ot met as evidenced by: n on 05/29/09, the facili t aid kit was available ir	ty							
	Finding include:									
		roduce a first aid kit up 1 stated "I don't have c								
H 044	Records of Residents	s-Copy of physical		H 044						
	home and resident comaintenance of record49.249) The operator of a hor 2. Maintain a separat	rds of residents. (NRS								

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home. Each file must include:

449.15523.

(d) A current copy of the assessment of the needs of the resident conducted pursuant to NAC

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2. A medical facility, a facility for the dependent or a home for individual residential care shall maintain surveillance of employees of the facility or home for tuberculosis and tuberculosis infection. The surveillance of employees must be

conducted in accordance with the

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4. An employee with a documented history of a positive tuberculosis screening test is exempt from screening with skin tests or chest

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There was no available files to review for

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cold, flu or other apparent illness; (5) Is experiencing night sweats:

has active tuberculosis.

(6) Is experiencing unexplained weight loss; or (7) Has been in close contact with a person who

(b) Within 24 hours after a person, including a person with a history of bacillus Calmette-Guerin (BCG) vaccination, is admitted to the facility or home, ensure that the person has a tuberculosis screening test, unless there is not a person

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that a person has had a cough for more than 3 weeks and that he has one or more of the other symptoms described in paragraph (a) of subsection 2, the person may be admitted to the facility or home if the staff keeps the person in

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(g) of subsection 1 of NAC 441A.200.

7. The staff of the facility or home shall ensure

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